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Nos. 93-1408, 93-1414 and 93-1415

In the Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

MARIO M. CUOMO, GOVERNOR OF NEW YORK, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

HOSPITAL ASSOCIATION OF NEW YORK STATE, PETITIONER

v.

TRAVELERS INSURANCE CO., ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

In three related statutes, New York State law imposes different surcharges on the rates hospitals charge, depending on whether the charges are paid by commercial insurers, health maintenance organizations, self-insured funds, or other specified payors. The question presented is:

Whether the surcharges, which apply to hospital care regardless of whether it is provided pursuant to a plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), are preempted by ERISA insofar as the hospital charges are covered by an ERISA plan.

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INTEREST OF THE UNITED STATES

This case presents questions concerning the scope of the preemption provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001-1169 (1988 & Supp. V 1993). See 29 U.S.C. 1144. The Secretary of Labor is primarily responsible for enforcing and administering Title I of ERISA. See 29 U.S.C. 1002(13), 1136(b). The United States therefore has a substantial interest in the resolution of the question presented. In response to the Court's invitation, the United States filed a brief at the petition stage of this case urging that certiorari be granted.

STATEMENT

1. New York State has a "comprehensive statutory scheme for the regulation of in-patient hospital rates." Pet. App. A64-A65.[1] For each of 794 diagnostic related groups (DRGs), a uniform rate is set that reflects the average cost of treating a patient with a particular condition, adjusted for each hospital to reflect factors such as its operating costs, capital costs, malpractice costs, and bad debt and charity care costs. In general, patients admitted to a hospital are assigned a DRG according to their condition, and are billed at the DRG rate for that particular hospital, rather than for the actual cost of treatment. *Id.* at A65.

In 1988 and 1992, the New York Legislature enacted laws requiring that hospital rates be calculated according not only to the DRG rate for the patient and hospital, but also according to who was paying for the services. The legislation prescribed three surcharges to be added to hospital rates:

First, a 13% surcharge was imposed on all hospital bills paid by a commercial insurer, by a "self-insured

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[1] All references to "Pet. App." are to the appendix to the petition for a writ of certiorari in No. 93-1414.

fund" that directly reimburses hospitals, or by certain workers' compensation, volunteer firefighters' and ambulance workers' benefits, and no-fault motor vehicle insurance funds. N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney 1993) (*reproduced at* Pet. App. A102-A103). The surcharge is paid to the hospital and retained by it.

Second, an additional surcharge of 11% was imposed on hospital bills paid by commercial insurers, raising the total surcharge for such payors to 24%. N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney 1993) (*reproduced at* Pet. App. A104). That surcharge was to be collected by hospitals, which were then to pay it into the State's general fund. The 11% surcharge was in effect only for a one-year period ending on March 31, 1993. *Ibid.*

Third, rates for services rendered to a member of a health maintenance organization (HMO) were surcharged 0% to 9%, depending on how close the member's particular HMO came to meeting a prescribed target for enrollment of Medicaid recipients.[2] N.Y. Pub. Health Law § 2807-c(2-a)(a)-(e) (McKinney 1993) (*reproduced at* Pet. App. A106-A113). The 0% to 9% surcharge is paid by the HMO directly into a statewide pool, and then into the State's general fund. N.Y. Pub. Health Law § 2807-c(2-a)(c)(i) (McKinney 1993) (*reproduced at* Pet. App. A111). See Pet. App. A65.

Some hospital bills are not subject to any surcharge. Services covered by Medicaid or by a Blue Cross/Blue Shield plan (the Blues) are billed at the DRG rate without a surcharge. N.Y. Pub. Health Law § 2807-c(1)(a) McKinney 1993) (*reproduced at* Pet. App. A101). Serv-

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[2] The Medicaid program, established by Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, provides federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons. See, *e.g.*, *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 36-40 (1981).

ices rendered to all other patients, including those patients who pay their own bills or who are reimbursed directly by self-insured funds or commercial insurers, are subject to the hospital's charges (not the DRG rate), with a statutory limit higher than that charged to commercial insurers. N.Y. Pub. Health Law § 2807-c(1)(c) (McKinney 1993) (*reproduced at* Pet. App. A103).

The purpose of the 13% surcharge is "to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers" by making the Blues—traditionally the "insurer of last resort" for high-risk individuals, see Pet. App. A28—more competitive with commercial insurers. *Id.* at A7-A8. The 11% surcharge has a similar purpose, and also was designed to increase state revenues. *Id.* at A8, A22, A72-A73 & n.8. "[T]he primary purpose of the [0% to] 9% assessment is to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program." *Id.* at A7-A8.

ERISA welfare plans pay for a large percentage of hospital bills in New York State. Pet. App. A6. "ERISA plans provide health coverage to employees in various ways, including: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the plan is directly responsible for health care bills * * *; (3) subscription to a health maintenance organization * * *; and (4) coverage through non-profit health service corporations, such as Blue Cross/Blue Shield plans." *Id.* at A6-A7. Thus, ERISA plans that provide hospitalization benefits either are purchasers of hospitalization coverage from commercial insurers or other payors, or are themselves payors of hospital bills.

2. This case presents the question whether the 13%, 11%, and 0% to 9% surcharges are preempted by ERISA. ERISA generally governs employee benefit plans, see 29 U.S.C. 1003(a), including any employee welfare benefit plan "established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or

otherwise, * * * medical, surgical, or hospital care or benefits." 29 U.S.C. 1002(1).

ERISA plans that provide benefits for participants by purchasing medical coverage—such as from commercial insurers, the Blues, or HMOs—are "insured plans." Plans that pay for participants' benefits out of the general assets of an employer's business are "self-insured plans," see *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 732 (1985), as are many multiemployer health plans. See 29 U.S.C. 1002(37) (1988 & Supp. V 1993); 26 U.S.C. 414(f). But not every arrangement by which an individual or group obtains health coverage is an ERISA covered plan. A plan subject to ERISA must be established by an "employer" or "employee organization" for the purpose of providing certain benefits to its "employee[s]." 29 U.S.C. 1002(1), (4)-(6). Health coverage obtained through arrangements that are unrelated to employment or based on an employment relationship that does not satisfy ERISA's coverage provisions is not covered by ERISA. See 29 U.S.C. 1003(b) (exclusion for governmental, church, and some other plans); cf. *Fugarino* v. *Hartford Life & Accident Ins. Co.*, 969 F.2d 178 (6th Cir. 1992) (sole proprietor), cert. denied, 113 S. Ct. 1401 (1993).

Section 514(a) of ERISA is an express preemption provision, which states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. 1144(a). The insurance savings clause of ERISA, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), however, limits the reach of the preemption clause. The savings clause states that, except as provided in the "deemer clause," described below, ERISA does not "exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." See App., *infra*, 1a. Thus, a law that "relates to" an ERISA-covered plan is not preempted if it is a law "which regulates insurance."

Finally, the savings clause is, in turn, limited by the "deemer clause" of ERISA, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B). That clause distinguishes between "an insurance company or other insurer * * * engaged in the business of insurance," to which the savings clause applies, and "an employee benefit plan," which shall not be "deemed" to be an insurance company or engaged in the business of insurance for preemption purposes. See App. *infra*, 1a. Thus, a state law that "relates to" an employee benefit plan that self-insures is preempted, even if such a law would otherwise be saved from preemption as a law "which regulates insurance." See *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61-63 (1990).

3. In two actions later consolidated, respondent insurance companies and their trade associations sought to invalidate and enjoin enforcement of the three New York surcharges on grounds that the surcharges are preempted by ERISA. The other respondents (including the New York State Health Maintenance Organization Conference and several HMOs) intervened in support of the insurers, and the New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and the Hospital Association of New York State intervened in support of the state defendants.

On cross-motions for summary judgment, the district court held that ERISA preempts all three surcharges, Pet. App. A63-A90, and it enjoined their enforcement "against any commercial insurers or HMOs in connection with their coverage of any ERISA plans." *Id.* at A89-A90. The court reasoned that the surcharges "relate to" ERISA plans because they impose "a substantial economic burden on the commercial insurers and HMOs," which affects the behavior of ERISA plans when it is passed on to them in the form of increased costs for health coverage. *Id.* at A71, A73. The court also concluded that none of the surcharges is saved as a law that regulates insurance under ERISA's insurance savings clause. *Id.* at A79-A80.

4. The court of appeals affirmed the district court's ruling that ERISA preempts all three surcharges. Pet. App. A17-A29, A34. The court held that, although the surcharge statutes "do not refer to ERISA plans," they "relate to" ERISA plans within the meaning of Section 514(a) because they "satisfy the less stringent 'connection with' standard embraced in *Ingersoll-Rand* [*Co.* v. *McClendon*, 498 U.S. 133 (1990)]." Pet. App. A22. The court found the requisite connection in the fact that, because the surcharges were designed to increase hospital costs for patients not covered by the Blues, "the surcharges purposely interfere with the choices that ERISA plans make for health care coverage." *Ibid.* Additionally, the court observed that "[t]he surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," forcing them "to increase either plan costs or reduce plan benefits." *Id.* at A23. The court rejected the argument that indirect economic impact alone does not suffice to justify a finding of preemption. *Id.* at A23-A24.

The court also ruled that the 11% and 13% surcharges are not saved from preemption under Section 514(b)(2)(A) of ERISA, 29 U.S.C. 1144(b)(2)(A), as laws "which regulate[] insurance." Reasoning as did the district court, the court held that the surcharges are not insurance laws as a matter of "common-sense" because they regulate hospital rates and are not directed at the insurance industry. Pet. App. A26-A27. The court rejected the argument that laws "designed to affect the insurance marketplace by giving the Blues a competitive advantage over * * * other players in the marketplace" amount to regulation of the "business of insurance," which the court believed to be the exclusive focus of ERISA's insurance savings clause. *Id.* at A27.

The court reached the same result applying the three factors considered under the McCarran-Ferguson Act, 15 U.S.C. 1011-1015, which this Court has held relevant to the determination whether a state law is saved under

ERISA's insurance savings clause. See, *e.g.*, *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 48-49 (1987). The court found that the 11% and 13% surcharges spread risk, and thus satisfy the first factor, by encouraging customers to shift to the Blues. Pet. App. A28. In the court's view, however, the second factor is not satisfied, because the surcharges "do not regulate any practice that is integral to the insurer-insured relationship." *Ibid.* The court reasoned that the surcharges "relate only to the contractual obligations between hospitals and insurers or insureds," rather than the relationship between the insurers and insureds. *Id.* at A29. Finally, the court held that the third factor is not satisfied, reasoning that the surcharges are not "limited to entities within the insurance industry" because the 11% and 13% surcharges affect non-insurance entities such as "the State, hospitals, patients, HMOs, and self-insured funds." *Ibid.* In two footnotes, the court approved the district court's holding that the 0% to 9% surcharge affecting only HMOs is not saved because HMOs do not engage in the business of insurance "as a matter of law." *Id.* at A26 n.5, A29 n.6.

SUMMARY OF ARGUMENT

New York State's surcharges do not "relate to" ERISA plans, because they are laws of general applicability that have only an indirect, economic effect on ERISA plans that purchase insurance and do not affect the interstate operation of such plans. Each of the surcharges is a law of general applicability, because it applies to broad categories of payors, each of which was intended to and does include both ERISA plans and participants and non-ERISA plans and participants. The impact of the surcharges on ERISA plans is indirect (since the surcharges apply to health insurance carriers, not insured ERISA plans themselves) and purely economic (since the surcharges affect only the costs of services ERISA plans purchase). The surcharges are unlikely to have any effect

on the interstate operation of ERISA plans, since hospital rates in any event vary widely within New York State and between New York and other States.

The court of appeals held that the surcharges were preempted, primarily because they "impose a significant economic burden on commercial insurers and HMOs * * * [and] therefore have an impermissible impact on ERISA plan structure and administration." Pet. App. 24. ERISA, however, does not preempt a state law simply because it causes the marketplace to provide certain economic incentives to ERISA plans to provide certain types of benefits to employees. Any form of regulation of hospital costs provides an incentive to purchasers of hospital care to tailor their conduct accordingly. A state regulation does not relate to plans so long as its only effect is to subject all buyers in a broad-based market in which ERISA plans and others substantially participate to a single set of marketplace incentives.

Even if the court of appeals were correct that the surcharges "relate to" ERISA plans, the court nonetheless erred in holding that the 11% and 13% surcharges are not saved by ERISA's insurance savings clause. The language of that clause is somewhat broader than the corresponding language of the McCarran-Ferguson Act. It is therefore appropriate to read the ERISA savings clause to save a somewhat broader range of state insurance regulation.

In this case, as a matter of "common sense," the surcharges on commercial insurers and HMOs are laws that regulate insurance. Although the surcharges are collected through the mechanism of hospital rates, their incidence is determined entirely by reference to the payor's status in the insurance industry. In addition, they are designed to give the Blues a rate advantage in the marketplace, thereby encouraging more customers to purchase coverage from the Blues and helping maintain the solvency of the Blues. The intended effects of the surcharges are there-

fore the traditional effects of insurance regulation—spreading risk, setting rates, and maintaining the solvency of insurers.

The same conclusion follows from an analysis of the three factors used to determine whether state regulation falls within the McCarran-Ferguson Act. As noted above, the surcharges serve a vital function in spreading risk. In addition, they affect the contract between insurer and insured because they are premised on the open-enrollment and community-rating policies of the Blues and HMOs, and their intended effect is on contract formation—to make hospitalization coverage more widely available at lower cost. Finally, the surcharges are generally limited to entities within the insurance industry, since their primary effect is on such entities.

ARGUMENT

A. THE SURCHARGE STATUTES DO NOT "RELATE TO" THE ERISA PLANS IN THIS CASE UNDER SECTION 514(a) BECAUSE THEY ARE GENERALLY APPLICABLE LAWS HAVING AN INDIRECT AND SOLELY ECONOMIC EFFECT ON ERISA PLANS

ERISA supersedes all state laws that "relate to" an ERISA plan. 29 U.S.C. 1144(a). A law "relates to" such a plan for purposes of Section 514(a) if it "has a connection with or reference to such a plan." *District of Columbia* v. *Greater Washington Bd. of Trade*, 113 S. Ct. 580, 583 (1992) (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). Section 514(a)'s preemptive reach is "conspicuous for its breadth." *FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990). Thus, a state law may "relate to" an ERISA plan "even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 (quoting *Ingersoll-Rand Co.* v. *McClendon*,

498 U.S. 133, 139 (1990)); see *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). The pre-emptive reach of Section 514(a) is not, however, unlimited. The fact that the operation of a state law "might burden the administration of a plan [does] not, by itself, compel pre-emption." *Ingersoll-Rand*, 498 U.S. at 139. In addition, "[s]ome state [laws] may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' " ERISA plans, *Shaw*, 463 U.S. at 100 n.21, "as is the case with many laws of general applicability." *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n.1. In this context, "a generally applicable statute" is one "that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139.

1. Each of the New York statutes imposing surcharges on hospital bills paid by HMOs and commercial insurers is a law "that makes no reference to, [and] indeed functions irrespective of, the existence of an ERISA plan," *Ingersoll-Rand*, 498 U.S. at 139, and that has an effect too "tenuous, remote, or peripheral" on employee welfare benefit plans to "relate to" them within the meaning of Section 514(a), *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n.1. The surcharges are laws of general applicability because they apply to categories of payors—commercial insurers, HMOs, self-insured funds, etc.—that are defined without regard to whether they provide health benefits for ERISA plans or participants in ERISA plans.[3] Moreover, each of the affected categories of

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[3] "Self-insured fund[s]" are among the enumerated payors of hospital bills subject to the 13% surcharge. Such funds include, but are not limited to, self-insured ERISA-covered plans. In our brief at the petition stage of this case, we stated that no self-insured fund is a plaintiff in this case. See Br. 14 n.5, 15 n.7 In

payors, as well as the Blues, in fact provides health coverage for both ERISA and non-ERISA plans and participants.

The only impact that the surcharges have on ERISA plans is indirect (because the surcharges do not apply to

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fact, the complaints filed in this case may be read to allege that one or more of the plaintiffs is a self-insured plan, see J.A. 93, at ¶ 18, and the complaints allege that several of the insured-plaintiffs in this case are fiduciaries for self-insured funds that are ERISA plans, see J.A. 69, 91-93.

The injunction in this case precludes enforcement of the surcharge "against any commercial insurers or HMOs in connection with their coverage of any ERISA plans." Pet. App. A89-A90. It is not clear that the district court's injunction, which bars application of the surcharge in connection with the insurers' "coverage" of ERISA plans, applies to situations in which commercial insurers serve as administrators of plans but do not extend insurance coverage to them. In any event, the injunction was not directed at self-insured plans generally. As we explained in our brief at the petition stage of this case at 14 n.5), "[a]pplication of the 13% surcharge to 'self-insured funds' may raise some distinct issues, since that surcharge applies to bills that some ERISA plans—those that self-insure—must pay themselves." Cf. 29 U.S.C. 1144(b)(5) (1988 & Supp. V 1993) (exempting Hawaii prepaid health care act from preemption, but stating that provision shall not be construed to exempt from 29 U.S.C. 1144(a) "any State tax law relating to employee benefit plans"). Therefore, the discussion in the text throughout addresses only insured plans.

Since no cross-appeal was taken from the district court's order, the application of the 13% surcharge to "self-insured fund[s]" was not raised by any party before the court of appeals. Nor did the court address it *sua sponte*. Therefore, if this Court agrees with our submission that the 13% surcharge is not preempted with respect to other entities to which it applies, the Court should not decide the question of the application of the surcharge to self-insured plans. Instead, the court should remand to the court of appeals (and, if necessary, to the district court) to determine in the first instance whether that issue is properly presented in this case and, if so, how it should be resolved in light of this Court's decision.

insured plans themselves, but are generally applicable to insurers and other health carriers whose services are purchased both by ERISA plans and others) and solely economic (because the surcharges affect only the costs of services ERISA plans purchase). The surcharges neither prescribe nor proscribe what hospitalization or other benefits a plan must afford; the eligibility standards for those benefits; the level of benefits offered; or the method of calculating benefits. The surcharges impose no substantive obligations on plans, and do not require them to conduct their administrative affairs in any particular way. Compare *Greater Washington Bd. of Trade, supra* (preempting statute mandating benefits to employees receiving workers' compensation that were tied directly to level of benefits set by plans); *FMC Corp., supra* (preempting law barring plans from enforcing subrogation claims on benefits); *Alessi, supra* (preempting law prohibiting plans from applying certain offsets to benefits).

Finally, the surcharges do not impede the interstate operation of ERISA plans, which ERISA's preemption clause was principally designed to protect. See *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987). The surcharges merely affect the calculation of fees paid for hospital care. Like other costs of doing business, those fees vary in any event from hospital to hospital and from region to region. In this respect, the surcharges are indistinguishable from any "state regulation under the police power which result[s] in increases in the cost of doing business" for plans. *United Wire, Metal & Machine Health & Welfare Fund* v. *Morristown Memorial Hosp.*, 995 F.2d 1179, 1196 (3d Cir.), cert. denied, 114 S. Ct. 382 (1993).

2. It is our submission that ERISA does not preempt state laws of general applicability that have *only* an indirect, economic effect on ERISA plans and do not

impede the interstate operation of such plans.[4] The court of appeals reached the contrary conclusion primarily on the ground that, in its view, "the surcharges purposely interfere with the choices that ERISA plans make for health care coverage." Pet. App. A22. In the court's view, "[t]he surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," forcing them "to increase either plan costs or reduce plan benefits." *Id.* at A23. That kind of impact, however, is insufficient to trigger preemption.

a. This Court has never held that a generally applicable state law that has a merely indirect, economic impact on ERISA plans is preempted under ERISA. To the contrary, in each case in which the Court has found preemption, the effect of the state law was either not indirect or not solely economic. For example, in *FMC Corp.*, 498 U.S. at 60, the Court held preempted a state statute regulating employee benefits plans that "prohibit[ed] [such] plans from being structured in a manner requiring reimbursement in the event of recovery [by a plan member] from a third party"; the statute's effect was thus both direct and not solely economic. In *Greater Washington Bd. of Trade*, 113 S. Ct. at 583, the Court held preempted a statute that "specifically refer[red] to welfare benefit plans regulated by ERISA" and that tied the level of state workers' compensation benefits to the level of benefits provided in the plans; its effect on such

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[4] In the court of appeals, the Secretary of Labor, appearing as amicus curiae, expressed the view that indirect economic impact is not a sufficient basis for ERISA preemption, but that the impact on choices made by plans provides a sufficient connection to trigger preemption. The Secretary took the position that the surcharges "relate to" ERISA plans on that narrow ground, but that—except for self-insured ERISA plans, which are protected by the "deemer" clause—they are saved from preemption by the insurance savings clause. The position stated in text is now the position of the Secretary.

plans was therefore direct. In *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987), the preempted common law cause of action was for damages arising from the improper processing of a claim for plan benefits, see *id.* at 48; it was preempted because it imposed administrative requirements directly on ERISA plans. Finally, in *Shaw*, 463 U.S. at 96-98, the preempted statute directly imposed requirements that employee benefit plans pay certain specified benefits and that they not discriminate on the basis of pregnancy.

Where it has expressly addressed the issue, this Court has been careful to distinguish the case of indirect, solely economic impact from the closer relation required to trigger ERISA preemption. For instance, in *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831 (1988), the Court acknowledged that Georgia's general garnishment statute would impose "substantial administrative burdens and costs" on ERISA plans. But the Court nonetheless held that the garnishment statute was not preempted. In *Ingersoll-Rand*, a wrongful discharge law that permitted a cause of action "premised on[] the existence of a * * * plan" did more than simply add an additional "cost" to the plan's "administrative burden." 498 U.S. at 139-140.[8]

Similarly, this Court found more than a merely indirect and economic impact before concluding that a law man-

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[8] Although this Court observed in *Alessi*, 451 U.S. at 525, that "even indirect state action bearing on private pensions may encroach upon" ERISA plans, the reference was to a New Jersey workers' compensation statute that by its terms prohibited plans from offsetting compensation awards against pension benefits. The statement was simply a reiteration of the principle that a statute need not be denominated a "pension regulation" in order to "relate to" pension plans. *Ibid.* In any event, it was clear that the New Jersey statute had more than a merely economic effect on ERISA plans; the statute did not merely give the plan an incentive to act, but rather "eliminate[d] one method for calculating pension benefits * * * that is permitted by federal law." *Id.* at 524.

dating insurers to include mental health benefits in their policies "clearly 'relate[s] to' welfare plans governed by ERISA." *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985). In that case, the Court implicitly recognized a legally significant difference between a law that substantially dictates an ERISA plan's choice of which benefits to provide participants by compelling insured plans to "purchase the * * * benefits specified in the statute when they purchase a certain kind of common insurance policy," *ibid.*, and a law that affects a plan's choice of benefits only by affecting the price of insurance purchased both by ERISA plans and by others in the State, see *id.* at 741 ("laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans in the first instance").

b. The consequence of adopting the court of appeals' theory of preemption based on mere indirect, economic impact would be both substantial and unwarranted. The court of appeals relied on the fact that the surcharges interfere with the choices made by ERISA plans. Pet. App. A22. But they do so in only one way: by increasing the relative cost of purchasing hospitalization coverage from some carriers, the surcharges make it less desirable for ERISA plans—along with anyone else purchasing health coverage in New York—to purchase coverage from those carriers.

The court of appeals' reasoning leads directly to the conclusion that ERISA plans are entirely exempt from the effects of any significant state regulation of the health care marketplace, for the court rested its conclusion on the existence of a type of interference with plan choice that is inherent in *any* form of regulation of hospital or medical costs.[6] For example, insofar as the DRG cate-

[6] In a more recent decision, the court of appeals acknowledged the breadth of its preemption theory. The court explained that a law that "targets only the health care industry," which "by defini-

gories themselves increase the costs of treatment for a particular medical condition, they provide a disincentive to ERISA plans to purchase insurance that provides coverage for that condition. And insofar as a given hospital is permitted, under the DRG system, to charge more than another hospital for the same service, the system provides a disincentive to plans to purchase insurance that provides benefits at the more expensive hospital. Indeed, even a state regulation, such as a tax, that resulted in an across-the-board increase in the costs of hospitalization would provide an incentive to ERISA plans to limit the hospitalization coverage they provide and to offer alternative benefits—either medical benefits or other types of employee benefits—instead.

Nor is the problem limited to cases in which state regulation increases the costs of some procedures, or of some hospitals, or of hospital costs generally. State regulation of ERISA plans is preempted whether it favors or disfavors such plans. See *Mackey*, 486 U.S. at 829-830. Thus, even state regulation that succeeded in *lowering* hospital costs for a given procedure, a given hospital, or hospital procedures in general would be found, under the court of appeals' theory, to "relate to" ERISA plans, since such regulation would provide an incentive for ERISA

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tion" is "the realm where ERISA * * * plans must operate," is "bound to affect" ERISA plans and thus "relate to" them. *NYSA-ILA Medical & Clinical Servs. Fund* v. *Axelrod*, 27 F.3d 823, 827 (2d Cir. 1994), petition for cert. pending, No. 94-745 (filed Oct. 21, 1994). The district court too acknowledged that, under this test, all state hospital rate-setting statutes will "relate to" employee benefit plans—and hence will be subject to ERISA preemption—insofar as "they apply to rates charged to patients that are participants in ERISA plans which include hospital expenses as a benefit." Pet. App. A77-A78; cf. *New England Health Care Employees Union Dist. 1199* v. *Mount Sinai Hosp.*, 846 F. Supp. 190, 195-198 (D. Conn. 1994) (relying on the Second Circuit's decision in this case to hold that ERISA preempts portions of Connecticut's hospital cost regulatory scheme), appeal pending, Nos. 94-7264 & 94-7906 (2d Cir.).

plans to alter their benefits packages and thus would interfere with the choices that ERISA plans make. Pet. App. A22.

Insofar as the surcharges at issue in this case affect plan choice, they do so only by subjecting ERISA plans to the same sort of marketplace incentives to which all other purchasers of health coverage are subject. So long as ERISA plans are subject to the same marketplace incentives as other purchasers of health coverage in New York, the fact that those incentives stem to some degree from generally applicable laws passed by the State—rather than from an entirely hypothetical free market in health care—is insufficient to preempt those state laws.

There is nothing in the text of the ERISA preemption clause, its legislative history (see *Shaw*, 463 U.S. at 99-100), or this Court's decisions construing the clause, to support a broad exemption for ERISA plans from the indirect and solely economic effects of generally applicable state laws on the health care marketplace. It is true that a large portion of the State's hospital bills are ultimately paid for by ERISA plans.[7] But the fact that ERISA plans are among the major participants in the health care marketplace does not convert regulation of that marketplace (for legitimate purposes unrelated to ERISA plans) into regulation that "relates to" ERISA plans.

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[7] The court of appeals noted that "[e]ighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans." Pet. App. A6. That figure is overstated and appears in any event to exclude non-elderly Americans who are uninsured. Nationwide, the percentage of nonelderly covered by employer-provided plans in 1992 (the most recent year for which figures are available) was 62.5%; that percentage, which includes participants in non-ERISA covered governmental and church plans, drops to 58.8% if the elderly are included. Employee Benefit Research Institute Issue Brief No. 145: *Special Report: Sources of Health Insurance and Characteristics of the Uninsured* 5 (Table 1) (Jan. 1994). In addition, because of deductibles, copayments, exclusions, and limitations, participants in ERISA-covered plans pay for a portion of their own hospital bills.

B. THE SURCHARGE STATUTES ARE IN ANY EVENT SAVED FROM PREEMPTION IN THIS CASE AS LAWS WHICH REGULATE INSURANCE

Having concluded that the 11% and 13% surcharges "relate to" ERISA plans, the court of appeals concluded that those surcharges are not saved by the ERISA insurance savings clause. In our view, the court erred in reaching that conclusion as well.[8]

1. ERISA's insurance savings clause, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), "substantially qualifie[s]" Section 514(a)'s otherwise broad preemption of state laws that "relate to" ERISA covered plans. *Metropolitan Life*, 471 U.S. at 733. The savings clause states that, except as provided in the "deemer clause," 29 U.S.C. 1144(b)(2)(B), ERISA does not "exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A). Thus, a law that regulates insurance is saved from preemption even if it "relate[s] to" ERISA plans. *FMC Corp.*, 498 U.S. at 61.

a. The determination of whether a state law regulates insurance within the meaning of ERISA's savings clause is largely a matter of "common-sense." *Metropolitan Life*, 471 U.S. at 740. "A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact

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[8] The court of appeals found—incorrectly, in our view—that HMOs "do not engage in the 'business of insurance' as a matter of law." Pet. App. A29 n.6. It therefore did not reach the further question of whether the particular characteristics of the 0% to 9% surcharge, which has a stated purpose different from that of the other surcharges (see p. 4, *supra*), render it a "law * * * which regulates insurance" within the meaning of the insurance savings clause. In our view, a law regulating HMOs *can* constitute a "law * * * which regulates insurance" under some circumstances. See pp. 25-26, *infra*. We understand, however, that no party argues in this case that the 0% to 9% surcharge is saved as a law that regulates insurance. This Court accordingly need not address that issue.

on the insurance industry, but must be specifically directed toward that industry." *Pilot Life*, 481 U.S. at 50 (general tort law applicable to, but not specifically directed toward, insurance industry not saved from preemption); accord *FMC Corp.*, 498 U.S. at 61 (state law must be "aimed at" the insurance industry, "not merely have an impact on" it).

Because "[t]he ERISA saving clause * * * appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States," *Metropolitan Life*, 471 U.S. at 744 n.21, the three criteria used to determine the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. 1012 (discussed at pp. 7-8, *supra*, and 24-27, *infra*), are also relevant in determining whether a law "regulates insurance" under ERISA. *Metropolitan Life*, 471 U.S. at 743. As in a McCarran-Ferguson Act case, however, "[n]one of these criteria is necessarily determinative in itself," *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982), and indeed, a law may be found to be an insurance law under ERISA's savings clause without resort at all to the *Pireno* factors. See *FMC Corp.*, 498 U.S. at 61 (finding that a law precluding subrogation is an insurance law, without mention of the *Pireno* factors).

b. Although this Court has recognized the relevance of analysis under the McCarran-Ferguson Act to questions regarding the scope of ERISA's insurance savings clause, it does not follow that the analysis is precisely the same under both statutes. Above all, consideration of whether a law "regulates insurance" under ERISA, while guided by "common sense" and the *Pireno* factors, must also be informed by "the role of the savings clause in ERISA as a whole." *Pilot Life*, 481 U.S. at 51. Indeed, the language of ERISA's insurance savings clause (as illuminated by the deemer clause) suggests that its sweep is somewhat broader than that of the McCarran-Ferguson Act.

The McCarran-Ferguson Act distinguishes between the "business of insurance," which it exempts from federal preemption, and the "business of insurance companies," which it does not exempt from federal preemption. *Hartford Fire Ins. Co.* v. *California*, 113 S. Ct. 2891, 2901 (1993); *SEC* v. *National Sec., Inc.*, 393 U.S. 453, 459 (1969). Under traditional McCarran-Ferguson Act analysis, not everything an insurance company does is within the "business of insurance." See *Pireno, supra* (use of chiropractic organization to provide peer review); *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979) (cost-saving arrangements with pharmacists).

In contrast, the ERISA savings clause is best read as encompassing insurance regulation generally. By its terms, the savings clause broadly states that ERISA does not exempt "any person from any law of any State *which regulates insurance*." 29 U.S.C. 1144(b)(2)(A) (emphasis added). That language suggests a broader sweep than the McCarran-Ferguson Act, whose grant of authority to the States to regulate and tax insurance is restricted to "[*t*]*he business of insurance*, and every person engaged therein." 15 U.S.C. 1012(a) (emphasis added).

The deemer clause further illuminates the scope of the savings clause. The deemer clause makes specific reference to state laws "purporting to regulate insurance companies [or] insurance contracts." 29 U.S.C. 1144(b)(2)(B). As stated in *Metropolitan Life*, 471 U.S. at 741, "[u]nless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans." Accord *FMC Corp.*, 498 U.S. at 64. By parity of reasoning, the savings clause would appear to extend to state laws "purporting to regulate insurance companies" with respect to aspects of their business other than their

insurance contracts, even if the McCarran-Ferguson Act would not exempt those laws from federal preemption. The deemer clause also makes specific reference to "an[y] insurance company *or other insurer*," 29 U.S.C. 1144 (b)(2)(B) (emphasis added), a phrase that encompasses entities in addition to traditional insurance companies. Reading the savings clause in light of this portion of the deemer clause, then, the state laws that "regulate[] insurance," and are therefore saved from preemption, must include those applicable not only to traditional insurance companies, but also to "other insurer[s]."

2. The 11% and 13% surcharge statutes are laws that regulate insurance within the common-sense meaning of that term. The court of appeals mistakenly believed that the surcharges regulate hospital rates and therefore cannot be regarded as regulating insurance. Pet. App. A26-A27. To the contrary, however, both surcharges are "specifically directed" toward the insurance industry for purposes of ERISA's insurance savings clause. See *Pilot Life*, 481 U.S. at 50.

First, the surcharges constitute insurance regulation because the determination whether a payor must pay them turns wholly on the payor's status as a participant in the insurance marketplace, and not on any factor concerning the nature of the hospital, the patient, his or her medical condition, or the medical treatment provided. To be sure, hospital bills provide the mechanism through which the surcharges are collected or distributed.[9] But that fact is insufficient to place the surcharges outside the

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[9] To the extent the 11% surcharge raised revenues for the State, see N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney 1993) (*reproduced at* Pet. App. A104), that fact does not diminish its status as an insurance regulation. Otherwise, a tax on insurance premiums could not be considered insurance regulation. See *General Motors Corp.* v. *California State Bd. of Equalization*, 815 F.2d 1305, 1309-1310 (9th Cir. 1987) (sustaining, under savings clause, tax assessment against insurer but calculated on basis of benefits paid), cert. denied, 485 U.S. 941 (1988).

ERISA savings clause; nothing in ERISA's savings clause "purports to distinguish between traditional and innovative insurance laws." *Metropolitan Life*, 471 U.S. at 741.

In addition, the surcharges serve traditional objectives of insurance law. Their primary function is to reduce the rate advantage enjoyed by commercial insurers and to account for the greater costs the Blues and some HMOs incur as a result of their open-enrollment and community-rating policies.[10] That function is related to traditional objectives of insurance regulation, such as risk spreading,[11] regulating rates,[12] and ensuring the solvency of insurers.[13] It speads the higher risks (which are now concentrated among the Blues) over a larger pool by encouraging a broadening of the Blues' customer base, at the expense of commercial insurers (and certain special-

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[10] Open enrollment means that the insurer will accept as an enrollee any person or group, and dependents, "at all times throughout the year" without regard to age, sex, physical condition, illness, or occupation, and will not terminate the enrollee "due to claims experience." N.Y. Ins. Law §§ 3231(a), 4317(a), 4318 (McKinney Supp. 1994). "[C]ommunity rat[ing]" means that the insurer employs "a rating methodology in which the premium for all persons covered by a policy or contract form is the same, based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation." *Id.* §§ 3231(a), 4317(a).

[11] See, *e.g.*, *Royal Drug*, 440 U.S. at 211-212 (the "spreading and underwriting of a policyholder's risk" is one "indispensable characteristic of insurance"); *Pireno*, 458 U.S. at 127-128.

[12] See, *e.g.*, *Metropolitan Life*, 471 U.S. at 728 n.2 ("[l]aws regulating aspects of transacting the business of group insurance include, for example, those regulating * * * rates"); *Royal Drug*, 440 U.S. at 224 n.32; *National Sec.*, 393 U.S. at 460 ("[c]ertainly the fixing of rates is part of th[e] [insurance] business").

[13] See, *e.g.*, *Metropolitan Life*, 471 U.S. at 728 n.2; see *United States Department of Treasury* v. *Fabe*, 113 S. Ct. 2202, 2209-2210 (1993).

ized funds).[14] The surcharges are designed to affect the calculation of insurance rates by reducing the cost differential that existed between the Blues and the other insurers. And by countering the effects of the commercial insurers' practice of selecting lower-risk individuals, the surcharges are intended to maintain the solvency of the Blues by alleviating the financial stress they have experienced as insurer of last resort.

3. The 11% and 13% surcharges also satisfy all three *Pireno* factors in this setting. As discussed above—and as the court of appeals correctly held, see Pet. App. A28—the surcharges satisfy the first factor of "transferring or spreading a policyholder's risk." *Metropolitan Life*, 471 U.S. at 743 (quoting *Pireno*, 458 U.S. at 129).

Contrary to the holding of the court of appeals, Pet. App. A28, the 11% and 13% surcharges also satisfy the second *Pireno* factor, because they regulate "an integral part of the policy relationship between the insurer and the insured." *Metropolitan Life*, 471 U.S. at 743 (quoting *Pireno*, 458 U.S. at 129). The surcharges are premised on the open-enrollment and community-rating policies of the Blues and HMOs—policies that are directly reflected in the formation of insurance contracts—and their purpose is to make hospitalization coverage available to more individuals, at an overall lower price. In addition, the surcharges establish "different payment rates" for different categories of payors, Pet. App. A27, with the specific intent of influencing the rates each category of payor charges.

Finally, the 11% and 13% surcharges satisfy the third *Pireno* factor because they are, in relevant respects, "limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743 (quoting *Pireno*, 458 U.S.

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[14] Indeed, the surcharge statutes are nearly identical in purpose and effect, albeit not method, to the law upheld in *Metropolitan Life* as a risk-shifting insurance regulation. See 471 U.S. at 731, 743.

at 129). The court of appeals held that the third factor is not satisfied because the surcharges "involve entities beyond the insurance industry," such as "the State, hospitals, patients, HMOs, and self-insured funds." Pet. App. A29. But the fact that the surcharges in some sense "involve" patients, hospitals, and the State is of little significance.[15] Insurance regulation generally is intended to have an effect on the customers of insurance companies —in this case, hospital patients—and to carry out the public policies of the State. So long as the amount of the surcharges is determined solely by the nature of the payor —*i.e.*, the payor's role in the insurance industry—the third factor is satisfied, regardless of the fact that hospitals collect both surcharges and retain the proceeds of the 13% surcharge.[16]

The court also erred in holding, as a matter of law, that HMOs are not part of the insurance industry for purposes of ERISA's insurance savings provision. See Pet. App. A26 n.5, A29 n.6. An HMO combines the function of an insurer (since for a set price it assumes the risk that a person will need medical care) and a

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[15] This Court has held that the protections of the McCarran-Ferguson Act should not be denied "*solely* because they involve parties outside the insurance industry." *Pireno*, 458 U.S. at 133. Although "the involvement of such parties * * * constitutes part of the inquiry" under that Act, it is "not dispositive." *Ibid*; see also *Hartford Fire*, 113 S. Ct. at 2902 ("the foreign reinsurers are hardly 'wholly outside the insurance industry' "), quoting *Royal Drug*, 440 U.S. at 231.

[16] Indeed, the New York statutes involve non-insurance entities to a far less degree than did the Ohio creditor priority statute that was found to be protected by the McCarran-Ferguson Act in *United States Department of Treasury* v. *Fabe*, 113 S. Ct. 2202 (1993). Although the Ohio statute regulated a relationship between policyholders and other competing creditors that had nothing to do with the business of insurance, this Court found the Ohio statute to be "confined entirely to entities within the insurance industry." *Id.* at 2209.

provider of medical care (since it generally either provides the medical care itself or arranges for others to provide the care).[17] See *Royal Drug*, 440 U.S. at 227 n.34, 230 n.37 (recognizing that "certain aspects" of advance-payment medical-benefits plans, such as the contract between the plan and its policyholders, may be the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. 1012). Therefore, insofar as the 11% and 13% surcharges "regulate" HMOs in their role as insurers in the same way that they "regulate" the Blues, *i.e.*, by exempting them from the surcharges, it is entirely appropriate to view the surcharges as an aspect of the regulation of insurers for ERISA preemption purposes.[18]

In any event, the third *Pireno* factor should not be applied rigidly when it is used in analysis under the ERISA savings clause. The third factor was developed to limit the term "business of insurance" in the second clause of Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), to entities within the insurance in-

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[17] The court of appeals itself recognized that HMOs provide "insurance" when it stated in a different portion of its opinion that "[e]ighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans." Pet. App. A6. See p. 18 n.7, *supra*. As the context makes clear, the court was including those who have HMO coverage among those who "have private health care *insurance*" (emphasis added).

[18] Many appellate courts have held that HMOs are insurers for certain purposes. *E.g.*, *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 891-892 (7th Cir. 1994) (ERISA); *In re Estate of Medcare HMO*, 998 F.2d 436, 444-445 (7th Cir. 1993) (Bankruptcy Code); *Stuart Circle Hosp. Corp.* v. *Aetna Health Management*, 995 F.2d 500, 501, 503 (4th Cir.) (ERISA), cert. denied, 114 S. Ct. 579 (1993); *Ocean State Physicians Health Plan, Inc.* v. *Blue Cross & Blue Shield*, 883 F.2d 1101, 1107-1108 (1st Cir. 1989) (McCarran-Ferguson Act), cert. denied, 494 U.S. 1027 (1990); *Klamath-Lake Pharmaceutical Ass'n* v. *Klamath Medical Serv. Bureau*, 701 F.2d 1276, 1287 (9th Cir.) (McCarran-Ferguson Act), cert. denied, 464 U.S. 822 (1983). The Blues are also insurers for those purposes. *Ocean State*, 883 F.2d at 1108.

dustry. An important rationale for that limitation is that the McCarran-Ferguson Act provides an exemption from the federal antitrust laws.[19] Such exemptions are narrowly construed, *Royal Drug*, 440 U.S. at 231, and in the insurance setting a broad construction could create "the potential to restrain competition in noninsurance markets." *Pireno*, 458 U.S. at 133; see also *Royal Drug*, 440 U.S. at 231 ("an exempt entity forfeits antitrust exemption by acting in concert with nonexempt parties"); *United States Department of Treasury* v. *Fabe*, 113 S. Ct. 2202, 2209-2210 (1993). By contrast, ERISA's insurance savings clause preempts any state law that "regulates insurance," not merely the "business of insurance," and the policy of narrowly construing exemptions from the antitrust laws is inapplicable here.

4. For the foregoing reasons, even if this Court concludes (contrary to our submission in Point A) that application of the 11% and 13% surcharges to commercial insurers and HMOs "relates to" the ERISA plans to which they sell coverage, those surcharges are preserved from preemption by the insurance savings clause.

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[19] Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), provides:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That * * * [the federal antitrust statutes] shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

The second clause is the portion following the word "*Provided*."

CONCLUSION

The judgment of the Second Circuit should be reversed.[20]

Respectfully submitted.

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[20] As stated in note 3, *supra*, the case should be remanded to afford the court of appeals (or the district court) an opportunity to address, in the first instance, whether the question of the application of the 13% surcharge to self-insured ERISA plans is presented in this case; and, if so, whether the 13% surcharge "relates to" self-insured ERISA plans. If the 13% surcharge is found to so relate, the court below would have the opportunity to address as well the application of the savings and deemer clauses to those plans.

APPENDIX

1. Section 514(a) of ERISA, 29 U.S.C. 1144(a), provides in full:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

2. Section 514(b)(2) of ERISA, 29 U.S.C. 1144(b)(2), provides in full:

> (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.